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Perspectives

The Ethical Importance of Assessing End-of-Life Care Preferences in Patients with Severe and Persistent Mental Illness

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It is well known that patients with severe and persistent mental illness (SPMI) have a high mortality rate (1-2) and die 10 to 20 years earlier than persons in the general population (3-4). One reason for their premature death is that SPMI is more likely to result in destructive somatic illnesses for a number of reasons. One such reason is that somatic illnesses are less likely to be diagnosed in SPMI patients (5); another reason is suicide, either by the patient's own hand or assisted by physicians (6).

A further issue is that after available evidence-based treatments have failed, patients with SPMI are at risk of incriminatory and futile interventions (7-8). However, as Yager has noted, treatment excesses and hyper-interventionism contrary to the patient's wishes are ethically unsupportable (9), a fortiori because there is evidence that most patients with mental disorders (including SPMI) have preserved decision-making capacity (e.g., 10).

It is important, then, that mental healthcare professionals take seriously the moral principle of patient self-determination, and that they move toward a model of shared decision-making that includes patients with SPMI (11). Assessment of patient preferences is a necessary prerequisite for shared decision-making; paradigmatic approaches to systematic consideration of patients' wishes include advanced care

planning (12) and psychiatric advance directives (13). These are also the central frames within which end-of-life care preferences should be discussed.

Elie and colleagues' article in this issue (14) heads in this direction, offering important insights into the end-of-life care preferences of patients with SPMI and those with chronic medical conditions. This study is important from medical, ethical, and legal points of view, as it addresses several issues of great societal interest in the context of mental health, including end-of-life preferences, palliative care, and physician-assisted dying.

The study's main finding was that SPMI patients are capable of voicing their end-of-life care preferences and, contrary to some fears, did not express a wish for medically assisted dying more often than non-SPMI patients with chronic medical conditions. Indeed, patients were receptive and were not seen to feel uncomfortable when talking about their end-of-life.

The authors defined SPMI as "any DSM-5 mental illness diagnosed for at least 2 years resulting in serious functional impairment" (p. X). With regard to this study population, the authors stated that they "cannot exclude that a more symptomatic SPMI population could have had different attitudes" (p. X). Indeed, it would be a worthwhile goal for further studies to assess the end-of-life preferences of more symptomatic patients with SPMI when last resort treatments have failed—for example, in the case of patients with therapy refractory major depression following unsuccessful electro-convulsive therapy or ketamine infusions, severe cases of chronic schizophrenia, or patients with end-stage anorexia nervosa. It may be that a higher percentage of those patients would opt for palliative care approaches (15) or physician-assisted dying than was reported by Elie and colleagues (14).

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